OFFICIAL DOCUMENT
AGing Needs Evaluation Summary
IHS – Title IIIE - HDM

I. Intake

I.A. Applicant Information

Client's first name

_____

Client's middle initial

_____

Client's last name

_____

In the past year, have you received services from more than one Wyoming senior center?

- [ ] No
- [ ] Yes

Client's mailing street address or post office box.

_____

Client's mailing city or town.

_____

Client's mailing state.

_____

Client's mailing ZIP code.

_____

Street address of where the client will be receiving services, if different from mailing address.

_____

City or town where the client will be receiving services, if different from mailing address.

_____

Client's telephone number.

_____

Last 4 digits of the clients Social Security number?

XXX – XX - _____

Directions to get to the client's home.

_____

_____

_____

_____

Does the client reside in a rural area?

- [ ] No (client lives in Casper. Cheyenne, Gillette, Laramie or Rock Springs)
- [ ] Yes

Specify the client's primary language.

- [ ] American Sign Language
- [ ] Basque
- [ ] English
- [ ] Filipino (Tagalog)
- [ ] French
- [ ] German
- [ ] Hebrew
- [ ] Italian
- [ ] Japanese
- [ ] Korean
- [ ] Mandarin
- [ ] Portuguese
- [ ] Romanian
- [ ] Russian
- [ ] Spanish
- [ ] Other

Does the client require a translator?

- [ ] No
- [ ] Yes (If yes, enter name of translator)

Name of the client's translator.

_____

Do you have difficulty reading and/or writing?

- [ ] No
- [ ] Yes

What is your date of birth?

_____/_____/_____

What is the client's gender?

- [ ] Female
- [ ] Male

What is your current marital status?

- ☐ Divorced
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ Married (If checked, must answer next 2 questions)

What is the name of your spouse/partner?

_____

_____

_____

_____

What is your spouse's/partner's date of birth?

_____/_____/_____

What is your race/ethnicity?

- ☐ African American
- ☐ American Indian/Native Alaskan
- ☐ Asian (not Pacific Islander/Hawaiian)
- ☐ Asian/Pacific Islander (incl. Hawaiian)
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hispanic Origin
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Non-Minority (White, non-Hispanic)
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Tongan
- ☐ Vietnamese
- ☐ Unavailable
- ☐ Other

Are you a veteran? (served active duty and honorably discharged)

- ☐ No
- ☐ Yes

Are you a spouse or dependent of a veteran?

- ☐ No
- ☐ Yes

What are the names and relationship of those present for the evaluation?

_____

_____

_____

_____

Did someone help the client or answer questions for the client?

- ☐ No
- ☐ Yes

What is the name and relationship of the person that helped the client during this evaluation?

_____

_____

_____

_____

Who are responsible for making decisions regarding your care, treatment, financial and legal affairs?

- ☐ Responsible for self
- ☐ Durable power attorney/financial
- ☐ Durable power of attorney/healthcare
- ☐ Informal decision maker
- ☐ Family member responsible
- ☐ Legal guardian
- ☐ Living will
- ☐ Representative or protective payee
- ☐ None of the above

I.B. Agency Information

What is the name of the agency the evaluator works for?

_____

What is the name of the person conducting this evaluation?

_____

Enter the date that the client was referred to the program.

_____/_____/_____

Who referred the client to your services?

_____

What is the date of this evaluation?

_____/_____/_____

Specify the type of evaluation, or the reason for the evaluation.

- [ ] CBIHS -Initial evaluation
- [ ] CBIHS - re-evaluation
- [ ] CBIHS -Change of status
- [ ] Family caregiver program - Initial evaluation
- [ ] Family caregiver program - Re-evaluation
- [ ] Family caregiver program - Change in status
- [ ] Home delivered meals - Initial evaluation
- [ ] Home delivered meals -Re-evaluation
- [ ] Home delivered meals - Change of status
- [ ] Title III B - In home services - Initial evaluation
- [ ] Title III B - In home services - Re-evaluation
- [ ] Title III B In home services - Change in status

I.C. Contact Information

Primary physician's name.

_____

Primary physician's telephone number.

_____

Name of an emergency contact

_____

What is the relationship between the client and the person who is listed as Emergency Contact?

_____

What is the telephone number of the person who is listed as Emergency Contact?

_____

I.D. Living Situation

Where was the client interviewed?

- [ ] Adult day care
- [ ] Home
- [ ] Home of relative/caregiver
- [ ] Hospital
- [ ] Mental health center
- [ ] Nursing facility
- [ ] Office of evaluator
- [ ] Other
- [ ] Wyoming state training school
- [ ] Wyoming state hospital

Do live in your in own home or apartment?

- [ ] No
- [ ] Yes

How many people, including yourself, reside in the household where you will be receiving services?

Select the client's living arrangement while receiving services, in the residence.

- [ ] Lives Alone
- [ ] Lives with child (not spouse)
- [ ] Lives with others (not spouse or children)
- [ ] Lives with paid help
- [ ] Lives with spouse and child
- [ ] Lives with spouse and others
- [ ] Lives with spouse only
- [ ] Lives with parents over age 60
- [ ] Other
- [ ] Lives in a group setting w/ non-relatives (if marked, must answer next question)

What is the client's group setting?

- [ ] Assisted Living
- [ ] Boarding Home
- [ ] Nursing Facility
- [ ] Senior Housing
- [ ] Other

II. Client Information

II.A. General

Is the client's gross income level below the annual Federal poverty level

- [ ] No
- [ ] Yes

What is the name of a person who regularly helps you? (unpaid help)

_____

How often does this person help you?

- [ ] Daily
- [ ] Monthly
- [ ] Other
- [ ] Weekly

What does this person help you do?

_____

_____

_____

_____

What support agencies assist you and how frequently?

_____

_____

_____

_____

List all types of transportation services the client is provided with.

- [ ] Assisted transportation
- [ ] Bus
- [ ] Drives self
- [ ] Escort needed
- [ ] Others drive
- [ ] Senior van
- [ ] Taxi

Are you currently using or participating in any of the following services or programs?

- [ ] Adult Day Health Care
- [ ] Loan Closet
- [ ] Assisted Living Facility
- [ ] Assistive Devices
- [ ] Caregiver Support
- [ ] Case Management
- [ ] Community Based Food Program (food bank)
- [ ] Community Mental Health Services
- [ ] Congregate Meals
- [ ] Energy Assistance (LEAP)
- [ ] Food Stamps
- [ ] Friendly Visitor/Telephone Assistance
- [ ] Hearing Assistance
- [ ] Home Health Services (Medicare)
- [ ] Home Delivered Meals
- [ ] Home health aide
- [ ] Hospice
- [ ] Housing Assistance
- [ ] IHS - Indian Health Services
- [ ] Independent Living Services
- [ ] Legal Services
- [ ] WY Guardianship Program
- [ ] Medicaid
- [ ] Medicaid Waiver
- [ ] Nursing
- [ ] Nutritional Counseling
- [ ] Occupational Therapy
- [ ] Public Health Nursing
- [ ] Older American Act Programs
- [ ] Ombudsman
- [ ] Personal Care
- [ ] Tax Rebate
- [ ] Physical Therapy
- [ ] Prescription Assistance
- [ ] Respiratory Therapy
- [ ] Respite Care
- [ ] Senior Center Services
- [ ] Senior Companion
- [ ] Substance Abuse Services
- [ ] Services for the Blind
- [ ] Speech Therapy
- [ ] SSI (Supplemental Security Income)
- [ ] Lifeline/personal emergency response
- [ ] Transportation
- [ ] Acquired Brain Injury Waiver
- [ ] Veterans Benefits
- [ ] Weatherization

II.B. Health Status

Have you recently been discharged from a hospital or nursing home (Within the last 3 months)?

- [ ] Don't know
- [ ] No
- [ ] Yes

Do you need help temporarily or permanently?

- [ ] Temporarily
- [ ] Permanently

Do you have difficulty breathing?

- [ ] No
- [ ] Yes, dependent on supplemental oxygen
- [ ] Yes, not being treated

Do you have a heart condition?

- [ ] No
- [ ] Yes - being treated
- [ ] Yes - not being treated

Do you have high blood pressure? (hypertension)

- [ ] No
- [ ] Yes, being treated
- [ ] Yes, not being treated

Do you have arthritis?

- [ ] No
- [ ] Yes - currently receives treatment or prescription
- [ ] Yes - does not receive treatment or prescription

Do you have any muscle or bone problems other than arthritis?

- [ ] No
- [ ] Yes, being treated
- [ ] Yes, not being treated

How many times have you fallen in the last 6 months?

Is the client missing any of the following? Please specify

- [ ] Arm(s)
- [ ] Finger(s)/Toe(s)
- [ ] Leg(s)
- [ ] Combination of choices
- [ ] No

Do you have any blood diseases? (i.e. Anemia, leukemia)

- [ ] No
- [ ] Yes, being treated
- [ ] Yes, not being treated

Have you been diagnosed or being treated for diabetes?

- [ ] No
- [ ] Yes - being treated
- [ ] Yes - not being treated

Do you have any allergies? (Food, medicine, environment)

- [ ] No
- [ ] Yes

Please describe the allergies

Does the client have a developmental disability?

- [ ] No
- [ ] Yes

Do you have any paralysis?

- [ ] None
- [ ] Partial
- [ ] Total

Have you ever had seizures?

- [ ] No
- [ ] Yes, being treated
- [ ] Yes, not being treated

Have you ever had a head injury?

- [ ] No
- [ ] Yes

Is the client confused?

- [ ] No
- [ ] Yes

Do you have any difficulty remembering?

- [ ] No
- [ ] Yes, being treated
- [ ] Yes, not being treated

Do you have vision problems?

- [ ] No
- [ ] Yes

Do you have a hearing impairment?

- [ ] No
- [ ] Yes

Have you ever had a pneumonia shot?

- [ ] Don't know
- [ ] No
- [ ] Yes

Have you had a flu shot this year?

- [ ] No
- [ ] Yes

Did you receive information about the vaccine for Shingles?

- [ ] No
- [ ] Yes

II.D. ADLs

Rate your ability to perform BATHING. (include shower, full tub or sponge bath, exclude washing back or hair)

- [ ] **0**-Independent
- [ ] **2**-Intermittent supervision or minimal physical assistance (stand by assistance)
- [ ] **4** -Partial assistance (can perform some but not all of the bathing activity)
- [ ] **6** -Total dependence

Rate the client's ability to perform EATING.

- [ ] **0**-Independent
- [ ] **2**-Limited assistance (need assistive devices or minimal physcial assistance)
- [ ] **4**-Extensive help (client needs continuous cueing, assistance or supervision)
- [ ] **6**-Total dependence

Rate the client's ability to perform DRESSING.

- [ ] **0**-Independent
- [ ] **1**-Limited physical assistance (help with zippers,buttons and adjusting clothing)
- [ ] **2**-Reminding, cueing or monitoring
- [ ] **3**-Extensive assistance
- [ ] **4**-Total dependence

Rate your ability to perform TOILET USE.

- [ ] **0**-Independent
- [ ] **2**-Reminding, cueing or monitoring
- [ ] **4**-Limited physical assistance (help adjusting clothing or incontinence supplies)
- [ ] **6**-Extensive assistance (wiping, cleaning or changing)
- [ ] **8**-Total dependence

Rate your ability to perform TRANSFER.

- [ ] **0**-Independent
- [ ] **1**-Limited physical assistance (includes assistive devices, ie walkers and canes)
- [ ] **2**-Extensive assistance (care provider uses assistive devices, gaitbelt, etc)
- [ ] **3**-Total dependence

Rate your mobility IN HOME.

- [ ] **0**-Independent
- [ ] **1**-Limited Physical Assistance (includes assistive devices, walkers and canes)
- [ ] 2-Extensive Assistance (includes assistive devices, gaitbelt, wheelchair)
- [ ] 3-Total dependence

II.E. IADLs

Rate your ability to perform MEAL PREPARATION.

- [ ] **0**-Independent
- [ ] **0**-Prepares simple or partial meals (frozen, ready-made food, cereal, sandwich)
- [ ] **1**-Prepares with verbal cueing or reminding
- [ ] **2**-Prepares with minimal help (cut, open or set up)
- [ ] **3**-Does not prepare any meals

Rate the client's ability to perform SHOPPING.

- [ ] **0**-Independent
- [ ] **2**-Does with supervision, verbal cueing or reminding only
- [ ] **4**-Shops with hands-on help or assistive devices
- [ ] **6**-Done by others or shops by phone

Rate your ability to perform MANAGING MEDICATIONS.

- [ ] **0**-Activity did not occur
- [ ] **0**-Independent
- [ ] **2**-Done with help some of the time
- [ ] **4**-Done with help all of the time

Specify your ability to MANAGE MONEY.

- [ ] **0**-Completely independent
- [ ] **2**-Needs assistance sometimes
- [ ] **4**-Needs assistance most of the time
- [ ] **6**-Completely dependent

Rank your ability to USE THE TELEPHONE.

- [ ] **0**-Independent
- [ ] **1**-Can perform with some human help
- [ ] **2**-Cannot perform function at all without human help

Rate your ability to perform HEAVY HOUSEWORK.

- [ ] **0**-Independent
- [ ] **1**-Needs assistance sometimes
- [ ] **2**-Does with maximum help
- [ ] **3**-Unable to perform tasks

Rate your ability to perform LIGHT HOUSEKEEPING.

- [ ] **0**-Independent
- [ ] **1**-Needs assistance sometimes
- [ ] **2**-Needs assistance most of the time
- [ ] **3**-Unable to perform tasks

Rate your ability to access TRANSPORTATION.

- ☐ **0**-Independent
- ☐ **1**-Done with help some of the time
- ☐ **2**-Done by others
- ☐ **3**-Requires ambulance

II.F. Home Environment

Does the client have safe access to all necessary areas of his/her home?

- ☐ No
- ☐ Yes

Are there electrical hazards in the home?

- ☐ No
- ☐ Yes

Does the client's home have stairs?

- ☐ Don't know
- ☐ No
- ☐ Yes

Sanitation hazards found in the client's home.

- ☐ Cluttered/soiled living area
- ☐ Inadequate sewage disposal
- ☐ Inadequate/improper food storage
- ☐ Insects/rodents present
- ☐ No toileting facilities
- ☐ No trash pickup
- ☐ None
- ☐ Other
- ☐ Outdoor toileting facilities

Does the client have problems with locks on the doors and/or windows in this home?

- ☐ No
- ☐ Yes

Is the bathroom adequate to meet the client's needs?

- ☐ No
- ☐ Yes

Does the client's kitchen appliances work properly?

- ☐ No
- ☐ Yes

Does the client have problems getting water or hot water in the home?

- ☐ No
- ☐ Yes

Can the temperature of the client's home be controlled to suit their needs?

- ☐ No
- ☐ Yes

Does the client have a functioning washer and/or dryer? Check which appliance(s) the client has access to use.

- ☐ Dryer
- ☐ Washer

Does the client have access to a telephone?

- ☐ No
- ☐ Yes

Are the steps and walkways outside the client's home in good condition?

- ☐ No
- ☐ Yes

Do you feel safe in this neighborhood?

- ☐ No
- ☐ Yes

Do you have any pets?

- ☐ No
- ☐ Yes (If marked, answer next question)

Does the client have adequate care for his/her pet(s)?

- ☐ No
- ☐ Yes

In the case of an emergency, would the client be able to get out of his/her home safely?

- ☐ No
- ☐ Yes, but with assistance
- ☐ Yes, no assistance needed

Does the client have fire hazards in his/her home environment?

- ☐ No
- ☐ Yes

Are smoke detectors present in this home?

- ☐ No
- ☐ Yes

Are there carbon monoxide detectors present in this home?

- ☐ No
- ☐ Yes

Is the client's home free from odor and pests?

- ☐ No
- ☐ Yes

II.G. Nutrition

I have an illness or condition that made me change the kind and/or amount of food I eat.

- ☐ **0**-No
- ☐ **2**-Yes, I have an illness or condition

I eat fewer than 2 meals every day.

- [ ] **0**-No
- [ ] **3**-Yes, I eat fewer than 2

I eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day.

- [ ] **0**-No
- [ ] **1**-Yes, I eat fewer than 5

I eat/drink fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day.

- [ ] **0**-No
- [ ] **1**-Yes, I have fewer than 2

I drink six (6) glasses of water, milk, fruit juice or decaffeinated beverage (excluding alcohol) each day. (one glass = 8 oz)

- [ ] **0**-No
- [ ] **0**-Yes, I drink at least 6 glasses

I have 3 or more drinks of beer, liquor or wine almost every day.

- [ ] **0**-No
- [ ] **2**-Yes, I have 3 or more

I have tooth, mouth or swallowing problems that make it difficult for me to eat.

- [ ] **0**-No
- [ ] **2**-Yes, I have problems (write the type of problem)

I eat alone most of the time.

- [ ] **0**-No
- [ ] **1**-Yes, I eat alone

I take 3 or more different prescribed or over-the-counter drugs every day.

- [ ] **0**-No
- [ ] **1**-Yes, I take 3 or more

I am not always able to shop, cook and/or feed myself.

- [ ] **0**-No, I am able
- [ ] **2**-Yes, I am not always able

Without wanting to, I have lost or gained 10 pounds in the past 6 months?

- [ ] **0**-Don't know
- [ ] **0**-No
- [ ] **2**-Yes, I have lost or gained

I don't always have enough money to buy the food I need.

- [ ] **0**-No
- [ ] **4**-Yes, I don't always have enough money

Describe the client's physician prescribed modified/therapeutic diet.

- [ ] Calorie Controlled
- [ ] Diabetic
- [ ] Not on a Special Diet
- [ ] Low Fat
- [ ] Low Salt
- [ ] Other

II.H. Eligible for Home Delivered Meals

Is the client homebound because he/she lives in a remote geographic location? (lives beyond the limits of public transportation)

- [ ] No
- [ ] Yes

Is the client homebound due to a recommendation from a physician, county health nurse or home health agency?

- [ ] No
- [ ] Yes

Is the client homebound due to frail health, illness or disability?

- [ ] No
- [ ] Yes

Is the client homebound due to mental or social limitations?

- [ ] No
- [ ] Yes

AGing Needs Evaluation Summary
Release Form

I give permission for sharing of information directly related to my health, social, environmental, and economic status with those agencies potentially providing services as necessary for up to one year to assist me in receiving the most appropriate care in the most appropriate environment. I further understand that data gathered as result of these services provided for me may be used in reporting and research. These results will be released to the Wyoming Department of Heath, Aging Division for statistical study, and my confidentially will be maintained.

- Refusal of any required information may result in full payment for services.

I understand by signing this form that:

- I may be considered for this program, whereas refusal to sign or submit needed information will be noted in my file, but will not be considered as the sole cause for denial to services under this program.
- If I feel I have been wrongly denied program services, or if the information is wrongfully used, I am entitled to a hearing.
- I have the right to inspect my own records, and their validity, amend data or request deletion of relevant individual case components.
- If I feel that services have not been of the quality expected, and/or not provided as stated in the service plan, I can contact the Wyoming Long Term Care Ombudsman at **(307) 322-5553** or the Wyoming Department of Health, Aging Division at **(800) 442-2766**.

Client's Signature: _____ Date: _____

Project Representative: _____ Date: _____

Determine Your Nutritional Health

The SAM's program automatically adds the point values from the Nutrition Questions to determine the when the nutritional risk of the client is "high" and the point value will show on the completed and printed copy. If the score is 6 or more, the program will automatically put "Yes" in the High risk question. However, the numerical values will not print on the non-completed hard copy. The table below is designed to help you determine the client's nutritional risk category (There is no "moderate" in the SAMS program).

Nutritional Risk Score	Nutrition Risk	Action
0-2	Low	Recheck in 6-12 months
3-5	Moderate	Recheck in 3-6 monthsProvide "Eating Well as We Age Brochure" or similar information.
6 or more	High	Provide the client a copy of the checklist for them to take to their health professional. Talk with the client about ways to improve their nutritional status.